

8571

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN lb <u>24 Hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> 15X-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Edgewater Apts</u>				d. STREET ADDRESS <u>3511 Randolph Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTIE EARNST BARTZ</u>				4. DATE OF DEATH Month Day Year <u>July 12 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30 1908</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>11 12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer-Depot Depense</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Dc</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles H. BARTZ</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE LOOS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		17. INFORMANT <u>Mrs Thelma Bartz</u> Address <u>3511 Randolph Rd Wheaton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion acute</u> DUE TO <u>Arterio-sclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (b) <u>2 yrs.</u> (c) <u>2 yrs.</u> DUE TO <u>2 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>Instant.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Francis J. Townsend, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND, JR.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUL 15 59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Frank</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse this certificate, writing it and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8570

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Potomac, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>R.F.D. 2.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SOLOMON CROPPER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1887</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Cropper</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Carr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Nellie Brittingham-Potomac</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 8</u> , 19 <u>59</u> , to <u>July 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>59</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. G. Crocker</u>				ADDRESS (Street, city or town, state) <u>New Church, Va.</u> DATE SIGNED <u>7-23-59</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Potomac, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharten</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 27 59</u>	
24b. REGISTRAR'S SIGNATURE <u>William E. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

STATE OF MASS.

DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO TOWN

DATE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO PARISH

DATE OF ENTRY INTO CHURCH

DATE OF ENTRY INTO SCHOOL

DATE OF ENTRY INTO EMPLOY

DATE OF ENTRY INTO SERVICE

DATE OF ENTRY INTO DEATH

DATE OF ENTRY INTO BURIAL

DATE OF ENTRY INTO CREMATION

DATE OF ENTRY INTO INTERMENT

DATE OF ENTRY INTO REPOSE

DATE OF ENTRY INTO REST

DATE OF ENTRY INTO SLEEP

DATE OF ENTRY INTO DEATH

DATE OF ENTRY INTO BURIAL

DATE OF ENTRY INTO CREMATION

8572

CERTIFICATE OF DEATH

118549

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BERLIN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS MAIN ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANIE Middle DAVIS Last DAVIS				4. DATE OF DEATH Month JULY Day 5 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1869		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME HARRY WALTERS				14. MOTHER'S MAIDEN NAME EMMA ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Address BERLIN NURSING HOME BERLIN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) High Hypertension & DUE TO (c) Arteriosclerosis & heart Chr.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 6-23 , 19 59 , to 7-5 , 19 59 that I last saw the deceased alive on 7-4 , 19 59 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Chas R. Law M.D.				ADDRESS (Street, city or town, state) Berlin Md.		DATE SIGNED 7-6-59	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/8/59	22c. NAME OF CEMETERY OR CREMATORY ROCKING-HAM		22d. LOCATION (City, town, or county) (State) BERLIN MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Anna H. Burby ADDRESS Berlin Md.				24a. REC'D BY REGISTRAR DATE JUL 10 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8573

Item 3 Film G244 7-21-59 e t

CERTIFICATE OF DEATH

08550

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>May</u> Last <u>Fields</u>				4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>E</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-15-77</u>	
9. AGE (In years and birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bates</u>				14. MOTHER'S MAIDEN NAME <u>Annie Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Virginia Powell</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443X</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C-V disease</u> DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from <u>9-13</u> , 19 <u>57</u> , to <u>7-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-2</u> , 19 <u>59</u> , and that death occurred at <u>3:00 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin Md</u>		DATE SIGNED <u>7/6/59</u>	
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr., MD</u>				PHYSICIAN'S ADDRESS <u>Berlin, Md</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leslie M. West</u>				ADDRESS <u>Salisbury, Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Finner</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>JUL 14 '59</u>			

FOR STATE
HEALTH DEPT.

8574

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin Md Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin, Md</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Walter Roger Harmon</i>		4. DATE OF DEATH Month <i>7</i> Day <i>27</i> Year <i>1959</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-23-1909</i> 50 yrs.
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>5</i>	11. IF UNDER 24 MRS. Hours <i>19</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Raising poultry farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Henry Harmon</i>		14. MOTHER'S MAIDEN NAME <i>Susan Hester Ellen Purnell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>4-1-1-1-1-1-1-1-1-1</i>	
17. INFORMANT <i>Florence Harmon</i>		Address <i>Berlin Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>824X</i> DUE TO <i>Base fracture of skull & Broken Neck</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Backward fall from moving truck to hard surface road</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>15 minutes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <i>Struck by a log in the moving truck, causing a fall</i>	
20c. TIME OF INJURY Month, Day, Year <i>8</i> a.m. <i>7-27-59</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <i>at Subroad</i>	
20e. PLACE OF INJURY (Home, farm, factory, shop, office bldg., etc.) <i>at Subroad</i>		20f. CITY OF TOWN (County) (State) <i>Berlin, Worcester Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>N.E. Sartorius Jr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>N.E. Sartorius</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>7/27/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/28/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Peter's Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Near Churchtown Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clinton F. Stewart</i>		ADDRESS <i>Salisbury Md</i>	
24a. REC'D BY REGISTRAR <i>DATE AUG 4 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8575 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

118552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ocean City Fair days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>N. Main St.</i>	
3. NAME OF DECEASED (Type or print) <i>Henry Long Harrison</i>		4. DATE OF DEATH Month <i>7</i> Day <i>4</i> Year <i>19-59</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 1 - 1897</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mrs. Harrison farms fruit grove</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZENSHIP WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Oslando Harrison</i>		14. MOTHER'S MAIDEN NAME <i>Addie H. Long</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Sec. Employed</i>	
17. INFORMANT <i>Hal Harrison</i>		Address <i>Berlin Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary disease</i> Conditions, if any, which gave rise to immediate cause (b) <i>?</i> (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Slight abrasion of forehead and nose when fell to floor</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>7-4-59</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Ocean City Worcester Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. E. Sartorius Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. E. Sartorius Jr.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/7/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>EVERGREEN</i>		22d. LOCATION (City, town, or county) (State) <i>BERLIN MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna A. Burbage</i>		ADDRESS <i>Berlin Md.</i>	
24a. REC'D BY REGISTRAR <i>JUL 10 '59</i>		24b. REGISTRAR'S SIGNATURE <i>C. L. S. Kline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

DATE OF DEATH: 12-15-1918
PLACE OF DEATH: HOME
AGE: 45
SEX: M
RACE: W
OCCUPATION: LABORER
CAUSE OF DEATH: HEART DISEASE
MANNER OF DEATH: NATURAL

DEATH CERTIFICATE
MAY BE USED FOR
VITAL STATISTICS
AND OTHER PURPOSES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the physician in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed, with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 9 Film G246 8-3-59 at

8576

CERTIFICATE OF DEATH

08553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DEL</u> b. COUNTY <u>CLAYMONT</u> 46X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>		c. LENGTH OF STAY IN 1b <u>1 WK.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		d. STREET ADDRESS <u>23 AVE C-</u>	
3. NAME OF DECEASED (Type or print) <u>WYETHAM H. HONEY</u>		4. DATE OF DEATH <u>JULY 26 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 22, 1872</u>
9. AGE (In years last birthday) <u>86 5/11</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRAINMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PENN R. R.</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH HONEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>140</u>	
17. INFORMANT <u>MR. SIMUEL BLAND, CLAYMONT DEL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Thrombosis sec</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Chronic Degenerative Inflammation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15-30 min</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26</u> , 19 <u>59</u> , to <u>July 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 26</u> , 19 <u>59</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Berlin, Md</u> DATE SIGNED <u>Berlin, Md</u>			
ACTUAL SIGNATURE <u>Annunzio Kohn</u>		M.D. <u>Berlin, Md</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>WILMINGTON DEL</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Buehler</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>JUL 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Buehler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

185554

Reg. Dist. No.

8577

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Bishop</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Sidney L. Hudson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken raiser</u>	
11. BIRTHPLACE (State or foreign country) <u>Worcester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sidney Hudson</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lulu Hudson</u>		Address <u>Bishop, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Bronchus Colon, &</u> <u>153.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic, Sigmoid</u> DUE TO (c) <u>Intestinal Stricture, see & above</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs.</u> <u>3 mo.</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1959</u> , to <u>July 5, 1959</u> , that I last saw the deceased alive on <u>July 7, 1959</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herman A. Robbins</u> M.D.		ADDRESS (Street, city or town, state) <u>Bishop, Md.</u> DATE SIGNED <u>7/10/59</u>	
PHYSICIAN'S NAME (Type) <u>HERMAN A. ROBBINS M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 12, 1959</u>	<u>Odd Fellows</u>	<u>Bishopville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		24a. REC'D BY REGISTRAR <u>JUL 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Evans</u>

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08555

CERTIFICATE OF DEATH

8578

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Berlin</u>		LENGTH OF STAY (in this place) —		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Berlin</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>RFD # 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ronald</u> (Middle) <u>Johnson</u> (Last)				(Month) <u>July</u> (Day) <u>4</u> (Year) <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>7-4-59</u>	9. AGE last birthday <u>5 mos.</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jessie James Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Mae Corbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mother, Berlin, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
7620 IMMEDIATE CAUSE (A) <u>Neonatal</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 mins</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Asphyxia</u>							
(C) <u>Obstruction of Airways</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work M.		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>at unattended birth</u> , 19 <u>1959</u> , that I last saw the deceased alive on <u>3:25A</u> , 19 <u>1959</u> , and that death occurred at <u>3:25A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George R. Sully, Jr.</u>		DATE THEREOF <u>7/5/59</u>		NAME OF CEMETERY OR CREMATORY <u>ST. Pauls</u>		LOCATION (City, town, or county) <u>Berlin</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/5/59</u>		NAME OF CEMETERY OR CREMATORY <u>ST. Pauls</u>		LOCATION (City, town, or county) <u>Berlin</u>	
24. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. King</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul D. Burtage</u>		ADDRESS <u>Berlin Md</u>	

1200289XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08556

8579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> <u>09-18-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Breakers Hotel</u>				d. STREET ADDRESS <u>100 West End Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Clifford</u> Last <u>Kruger</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 22 1912</u> 47 yrs.	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>PAUL KRUGER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA M. VOSSLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Mabel Kruger (wife)</u> Address <u>Cambridge MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION Acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEN. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LECOMPT FUNERAL SERVICE</u>				ADDRESS <u>CAMBRIDGE MARYLAND</u>		24a. REC'D BY REGISTRAR <u>Jul 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knapp</u>		DATE SIGNED <u>July 19, 1959</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the certificate, writing it and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

THE UNIVERSITY OF CHICAGO

8580

CERTIFICATE OF DEATH

08557

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS WEST ST			
3. NAME OF DECEASED (Type or print) First Middle Last LAURA JANE LITTLETON				4. DATE OF DEATH Month Day Year JULY 25 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 1, 1865	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM SARMAN				14. MOTHER'S MAIDEN NAME MARY ANNE TIMMONS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address MR. SEWELL LITTLETON BERLIN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Cardiac failure DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Severe atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2-3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Seizure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 25, 1953 to July 25, 1959 , that I last saw the deceased alive on July 25, 1959 , and that death occurred at MD from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Grubb MD				ADDRESS (Street, city or town, state) BERLIN, MD. DATE SIGNED 7/27/59			
PHYSICIAN'S NAME (Type) ROBERT A. GRUBB, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/28/59		22c. NAME OF CEMETERY OR CREMATORY BUCKINGHAM		22d. LOCATION (City, town, or county) (State) BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Anna A. Buntz Berlin Md				24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9520

Page One of Two

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]		9. EDUCATION [Faint text]		10. RELIGION [Faint text]		11. SOCIAL SECURITY NUMBER [Faint text]		12. MOTHER'S MAIDEN NAME [Faint text]	
13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]		15. PLACE OF DEATH [Faint text]		16. CAUSE OF DEATH [Faint text]		17. MANNER OF DEATH [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF WITNESS [Faint text]		20. SIGNATURE OF PHYSICIAN [Faint text]		21. SIGNATURE OF CORONER [Faint text]		22. SIGNATURE OF JURY [Faint text]		23. SIGNATURE OF JUDGE [Faint text]		24. SIGNATURE OF CLERK [Faint text]	

OFFICE OF THE ATTORNEY GENERAL
STATE OF MARYLAND
BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08558

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Dauphin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>24 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrisburg</u>		<u>75X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Boat in Sinepuxent Bay</u>				d. STREET ADDRESS <u>707 Mountain Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Arthur</u> Middle <u>Luckett</u> Last				4. DATE OF DEATH <u>July</u> Month <u>13</u> Day <u>19</u> Year <u>59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 14, 1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Luckett</u>				14. MOTHER'S MAIDEN NAME <u>Emma Deitrich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>207-07-9869</u>		17. INFORMANT Address <u>707 Mountain Rd Harrisburg Pa</u> <u>Mrs Lucille Hall, daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arterio sclerotic (C.V.D.)</u> (c) <u>Arterio sclerotic (C.V.D.)</u> DUE TO <u>Arterio sclerotic (C.V.D.)</u> cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>2 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EAST HARRISBURG</u>		22d. LOCATION (City, town, or county) (State) <u>HARRISBURG PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Burbage</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing it and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

8582

CERTIFICATE OF DEATH

08559

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin				c. LENGTH OF STAY IN 1b 39yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXXX				d. STREET ADDRESS North Main St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRANK A. MAGEE				4. DATE OF DEATH Month Day Year July 13 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1875		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Oil Distributor		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Magee				14. MOTHER'S MAIDEN NAME Laura Birch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Raymond Magee Berlin, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sudden myocardial failure DUE TO possible Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) extensive arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 15 mins 1/2 hour	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1954 to July 13, 1959 , that I last saw the deceased alive on July 13, 1959 , and that death occurred at 12:30 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Grubb MD				ADDRESS (Street, city or town, state) BERLIN, Md.		DATE SIGNED 7/14/59	
PHYSICIAN'S NAME (Type) ROBERT A. GRUBB							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/59		22c. NAME OF CEMETERY OR CREMATORY I. O. O. F.		22d. LOCATION (City, town, or county) (State) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter W. ...				24a. REC'D BY REGISTRAR DATE JUL 16 59		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08560

8583

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Northampton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Md</u>	c. LENGTH OF STAY IN 1b <u>✓</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wardtown</u>	83x-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Route 113</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John Wm. Mapp</u>	4. DATE OF DEATH <u>July 31 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7 1937</u>
9. AGE (In years, months, days) <u>21 9 54</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Massawadee Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Larry P. Mapp</u>		14. MOTHER'S MAIDEN NAME <u>Ortha Cisher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>254-48-1334</u>	
17. INFORMANT <u>Mr. Harry P. Mapp</u>		Address <u>Wardtown Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 816x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TRAUMA</u> (c) <u>TRUCK COLLISION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>FRACTURE LEFT HUMERUS & FRACTURE RIGHT TIBIA</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>TRUCK COLLISION US 113 3 MILES N. of SNOW HILL</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:00 a.m. 7/31 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. 113</u>	20f. (City or town) <u>SNOW HILL</u> (County) <u>WORCESTER</u> (State) <u>MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert C. LaMar</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Robert C. LaMar</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial Aug. 2/59</u>		22b. DATE THEREOF <u>Aug. 2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Belle Haven Cemetery</u>		22d. LOCATION (City, town, or county) <u>Belle Haven, Virginia</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alley & Dennis Snowhill, Inc.</u>		24. REC'D BY REGISTRAR <u>AUG 3 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Ortha C. Fisher</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
HEALTH DEPT.

2282

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MATTHEW

DECEASED

DATE OF DEATH
A. COOK

SEX
AGE

DEATH

DEATH

☐ Cause of death is a disease of the heart or lungs
☐ Cause of death is a disease of the brain
☐ Cause of death is a disease of the stomach or intestines
☐ Cause of death is a disease of the liver or kidneys
☐ Cause of death is a disease of the spleen or pancreas
☐ Cause of death is a disease of the gall bladder or biliary system
☐ Cause of death is a disease of the urinary system
☐ Cause of death is a disease of the reproductive system
☐ Cause of death is a disease of the endocrine system
☐ Cause of death is a disease of the circulatory system
☐ Cause of death is a disease of the respiratory system
☐ Cause of death is a disease of the digestive system
☐ Cause of death is a disease of the muscular system
☐ Cause of death is a disease of the nervous system
☐ Cause of death is a disease of the skin
☐ Cause of death is a disease of the bones or joints
☐ Cause of death is a disease of the eyes or ears
☐ Cause of death is a disease of the nose or throat
☐ Cause of death is a disease of the mouth or tongue
☐ Cause of death is a disease of the teeth
☐ Cause of death is a disease of the hair or nails
☐ Cause of death is a disease of the skin or mucous membranes
☐ Cause of death is a disease of the blood or lymphatic system
☐ Cause of death is a disease of the immune system
☐ Cause of death is a disease of the nervous system
☐ Cause of death is a disease of the endocrine system
☐ Cause of death is a disease of the circulatory system
☐ Cause of death is a disease of the respiratory system
☐ Cause of death is a disease of the digestive system
☐ Cause of death is a disease of the muscular system
☐ Cause of death is a disease of the nervous system
☐ Cause of death is a disease of the skin
☐ Cause of death is a disease of the bones or joints
☐ Cause of death is a disease of the eyes or ears
☐ Cause of death is a disease of the nose or throat
☐ Cause of death is a disease of the mouth or tongue
☐ Cause of death is a disease of the teeth
☐ Cause of death is a disease of the hair or nails
☐ Cause of death is a disease of the skin or mucous membranes
☐ Cause of death is a disease of the blood or lymphatic system
☐ Cause of death is a disease of the immune system

Signature of Medical Examiner
Date

Signature of Coroner
Date

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8584 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08561

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	c. LENGTH OF STAY IN 1b <u>4 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Andrew</u> Middle <u>Parker</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 23-1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		9. AGE (In years last birthday) yrs. <u>6</u> 1/2	11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>
13. FATHER'S NAME <u>Richard Lee Parker</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Watkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sarah Elizabeth Watkins</u> Address <u>Snow Hill, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (probably)</u> <u>493 X</u> DUE TO (b) <u>Cold + Malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrocephalus</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N. E. Sartorius</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/19/59</u> (State) <u>Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Whitcomb Cemetery</u>		22d. LOCATION (City, town, or county) <u>Snow Hill, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Gumm</u> ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

42082214 XV6

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8585

Item 8 Film G244 7-21-59 et

CERTIFICATE OF DEATH

08562

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Girtletree d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Girtletree d. STREET ADDRESS R.D.# 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MILLIE Middle PARSONS Last PARSONS		4. DATE OF DEATH Month JULY Day 12th Year 19 59					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880 Dec. 14, 1879	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY Wisconsin		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME - - - - - Farington		14. MOTHER'S MAIDEN NAME - - - - - (Unk)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Mr. Asbury Parsons (Husband) R.D.# 1 Girtletree, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 min 5 yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. , 19 58 , to July , 19 59 that I last saw the deceased alive on May 15 , 19 59 , and that death occurred at 9:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John M. Bender M.D. July 14 / 1959 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Dr. John M. Bender 215 W. Martin St. Snow Hill, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial- July 15, 1959		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUL 16 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Frank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

8586

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08563

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG246 7-31-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MA</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Francis Purnell</u>		4. DATE OF DEATH <u>7 19 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1914</u>
9. AGE (in years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>MA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Kate Purnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-12-1047</u>	
17. INFORMANT <u>Margie Purnell</u>		Address <u>Berlin</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>Coronary Artery Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Serious Asthmatic Symptoms with severe anginal pectoris</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N. E. Sartorius</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 22 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sarah Dubois Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin MA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke Md</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

8888

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible] AGE: [illegible]
3. DATE OF BIRTH: [illegible]
4. PLACE OF BIRTH: [illegible]
5. OCCUPATION: [illegible]
6. MARITAL STATUS: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF EXAMINER: [illegible]
10. DATE OF EXAMINATION: [illegible]

RECEIVED
BALTIMORE
MAY 10 1968

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible] AGE: [illegible]
3. DATE OF BIRTH: [illegible]
4. PLACE OF BIRTH: [illegible]
5. OCCUPATION: [illegible]
6. MARITAL STATUS: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF EXAMINER: [illegible]
10. DATE OF EXAMINATION: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your office. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

8587 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Land</u> Last <u>Tull</u>		4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u> 6. COLOR OR RACE <u>E</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1891</u> 9. AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lynwood Tull</u>		14. MOTHER'S MAIDEN NAME <u>Laura Riddle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-5650</u> 17. INFORMANT <u>Woodward Tull</u> Address <u>Pocomoke, MD</u>	
18. CAUSE OF DEATH (Enter only 100 words per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia (lobar)</u> (c) <u>refort</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>DK</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>3</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N. E. Sartorius Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church St.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 15 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

6583 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>	
3. AGE <i>45</i>		4. DATE OF DEATH <i>10/15/1918</i>	
5. PLACE OF DEATH <i>123 Main St. Boston</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. OCCUPATION <i>Engineer</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocarditis</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF EXAMINER <i>Dr. J. A. Smith</i>		12. SIGNATURE OF WITNESSES <i>John J. Brown, Jr.</i>	
13. SIGNATURE OF CLERK <i>John J. Brown</i>		14. SIGNATURE OF JURY <i>John J. Brown</i>	
15. SIGNATURE OF JURY <i>John J. Brown</i>		16. SIGNATURE OF JURY <i>John J. Brown</i>	
17. SIGNATURE OF JURY <i>John J. Brown</i>		18. SIGNATURE OF JURY <i>John J. Brown</i>	
19. SIGNATURE OF JURY <i>John J. Brown</i>		20. SIGNATURE OF JURY <i>John J. Brown</i>	
21. SIGNATURE OF JURY <i>John J. Brown</i>		22. SIGNATURE OF JURY <i>John J. Brown</i>	
23. SIGNATURE OF JURY <i>John J. Brown</i>		24. SIGNATURE OF JURY <i>John J. Brown</i>	
25. SIGNATURE OF JURY <i>John J. Brown</i>		26. SIGNATURE OF JURY <i>John J. Brown</i>	
27. SIGNATURE OF JURY <i>John J. Brown</i>		28. SIGNATURE OF JURY <i>John J. Brown</i>	
29. SIGNATURE OF JURY <i>John J. Brown</i>		30. SIGNATURE OF JURY <i>John J. Brown</i>	
31. SIGNATURE OF JURY <i>John J. Brown</i>		32. SIGNATURE OF JURY <i>John J. Brown</i>	
33. SIGNATURE OF JURY <i>John J. Brown</i>		34. SIGNATURE OF JURY <i>John J. Brown</i>	
35. SIGNATURE OF JURY <i>John J. Brown</i>		36. SIGNATURE OF JURY <i>John J. Brown</i>	
37. SIGNATURE OF JURY <i>John J. Brown</i>		38. SIGNATURE OF JURY <i>John J. Brown</i>	
39. SIGNATURE OF JURY <i>John J. Brown</i>		40. SIGNATURE OF JURY <i>John J. Brown</i>	
41. SIGNATURE OF JURY <i>John J. Brown</i>		42. SIGNATURE OF JURY <i>John J. Brown</i>	
43. SIGNATURE OF JURY <i>John J. Brown</i>		44. SIGNATURE OF JURY <i>John J. Brown</i>	
45. SIGNATURE OF JURY <i>John J. Brown</i>		46. SIGNATURE OF JURY <i>John J. Brown</i>	
47. SIGNATURE OF JURY <i>John J. Brown</i>		48. SIGNATURE OF JURY <i>John J. Brown</i>	
49. SIGNATURE OF JURY <i>John J. Brown</i>		50. SIGNATURE OF JURY <i>John J. Brown</i>	
51. SIGNATURE OF JURY <i>John J. Brown</i>		52. SIGNATURE OF JURY <i>John J. Brown</i>	
53. SIGNATURE OF JURY <i>John J. Brown</i>		54. SIGNATURE OF JURY <i>John J. Brown</i>	
55. SIGNATURE OF JURY <i>John J. Brown</i>		56. SIGNATURE OF JURY <i>John J. Brown</i>	
57. SIGNATURE OF JURY <i>John J. Brown</i>		58. SIGNATURE OF JURY <i>John J. Brown</i>	
59. SIGNATURE OF JURY <i>John J. Brown</i>		60. SIGNATURE OF JURY <i>John J. Brown</i>	
61. SIGNATURE OF JURY <i>John J. Brown</i>		62. SIGNATURE OF JURY <i>John J. Brown</i>	
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65. SIGNATURE OF JURY <i>John J. Brown</i>		66. SIGNATURE OF JURY <i>John J. Brown</i>	
67. SIGNATURE OF JURY <i>John J. Brown</i>		68. SIGNATURE OF JURY <i>John J. Brown</i>	
69. SIGNATURE OF JURY <i>John J. Brown</i>		70. SIGNATURE OF JURY <i>John J. Brown</i>	
71. SIGNATURE OF JURY <i>John J. Brown</i>		72. SIGNATURE OF JURY <i>John J. Brown</i>	
73. SIGNATURE OF JURY <i>John J. Brown</i>		74. SIGNATURE OF JURY <i>John J. Brown</i>	
75. SIGNATURE OF JURY <i>John J. Brown</i>		76. SIGNATURE OF JURY <i>John J. Brown</i>	
77. SIGNATURE OF JURY <i>John J. Brown</i>		78. SIGNATURE OF JURY <i>John J. Brown</i>	
79. SIGNATURE OF JURY <i>John J. Brown</i>		80. SIGNATURE OF JURY <i>John J. Brown</i>	
81. SIGNATURE OF JURY <i>John J. Brown</i>		82. SIGNATURE OF JURY <i>John J. Brown</i>	
83. SIGNATURE OF JURY <i>John J. Brown</i>		84. SIGNATURE OF JURY <i>John J. Brown</i>	
85. SIGNATURE OF JURY <i>John J. Brown</i>		86. SIGNATURE OF JURY <i>John J. Brown</i>	
87. SIGNATURE OF JURY <i>John J. Brown</i>		88. SIGNATURE OF JURY <i>John J. Brown</i>	
89. SIGNATURE OF JURY <i>John J. Brown</i>		90. SIGNATURE OF JURY <i>John J. Brown</i>	
91. SIGNATURE OF JURY <i>John J. Brown</i>		92. SIGNATURE OF JURY <i>John J. Brown</i>	
93. SIGNATURE OF JURY <i>John J. Brown</i>		94. SIGNATURE OF JURY <i>John J. Brown</i>	
95. SIGNATURE OF JURY <i>John J. Brown</i>		96. SIGNATURE OF JURY <i>John J. Brown</i>	
97. SIGNATURE OF JURY <i>John J. Brown</i>		98. SIGNATURE OF JURY <i>John J. Brown</i>	
99. SIGNATURE OF JURY <i>John J. Brown</i>		100. SIGNATURE OF JURY <i>John J. Brown</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18565

8588

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u> 22 x 2			
c. LENGTH OF STAY IN 1b <u>2 months</u>				d. STREET ADDRESS <u>None</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Street - 20th & Baltimore Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>KIRKE Whitehouse Wailes</u>				4. DATE OF DEATH <u>JULY 8 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 3, 1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenr, Retired Building</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nanticoke Md</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John William Wailes</u>				14. MOTHER'S MAIDEN NAME <u>Jelly Anne Douglas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217010964</u>			
17. INFORMANT <u>Mabel Wailes</u>				Address <u>Nanticoke Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion Acute</u> DUE TO <u>Arteriosclerotic (CVD)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>2 years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Instant.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Francis J. Townsend Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANCIS J TOWNSEND JR. ASST</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messing, Bishop, Md.</u>				24a. REC'D BY REGISTRAR <u>Jul 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Julius S. Hanes</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar, near to burial, cremation, or removal.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8589 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark Rural Life Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin, MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Earl</u> <u>Harrison</u> <u>Waples</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28-1933</u> 25 yrs.
9. AGE (In years last birthday) <u>25</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		11. BIRTHPLACE (State or foreign country) <u>Bushfield, Worcester</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Bryan Waples</u>	
14. MOTHER'S MAIDEN NAME <u>Kella C. Pates</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-30-8245</u>		17. INFORMANT <u>Mr. F. H. Waples</u> Address <u>Berlin, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neglect Skull fractures with</u> <u>923X</u> DUE TO <u>fracture of vertebrae</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Auto-accident</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dr. Waples, physician at the school</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>After leaving hospital at 4:00 p.m. 7-25-59</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>After leaving hospital at 4:00 p.m. 7-25-59</u>			
20c. TIME OF INJURY Month, Day, Year <u>7-25-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, etc.) <u>Home</u>		20f. (City or town) <u>Berlin</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>N. E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		22d. LOCATION (City, town, or county) <u>Berlin, MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Watson</u>		ADDRESS <u>Re Delby</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		DATE <u>JUL 29 '59</u>	
24b. REGISTRAR'S SIGNATURE			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE STATE HEALTH COMMISSIONER
ALBANY, N. Y.
JANUARY 1, 1910

STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE STATE HEALTH COMMISSIONER
ALBANY, N. Y.
JANUARY 1, 1910

NAME OF PATIENT: []
AGE: [] SEX: []
RESIDENCE: []
DATE OF BIRTH: []
DATE OF DEATH: []
CAUSE OF DEATH: []
PLACE OF DEATH: []
MANNER OF DEATH: []
OCCUPATION: []
EDUCATION: []
RELIGION: []
MARRIAGE: []
CHILDREN: []
SIBLINGS: []
PARENTS: []
GRANDPARENTS: []
BROTHERS: []
SISTERS: []
AUNT: []
UNCLE: []
Nephew: []
Niece: []
Cousin: []
Other: []